These expanded instructions and explanations should be used to assist in the accurate completion of the Monthly Assessment Fee Statement.

- Provider Assessment is based on all ICF-MR non-Medicare Occupied bed days.

- Provider's Month End and Year End Totals (Occupied bed days) must agree with the provider's midnight census as well as with the year end cost report days.

1. Facility Name: Enter the ICF-MR Facility name as it appears on the intermediate care license. Enter the name consistently on each month's report.

2. Provider Number: Enter the ICF-MR Medicaid provider number.

3. Federal Tax ID Number: Enter the Federal Tax Identification number.

4. Total Medicaid Occupied Bed Days, Current Month Ended Total: Enter the number of ICF-MR occupied bed days or payable by North Carolina Medicaid through the ICF-MR reimbursement program for the current month based on dates of service (not including Piedmont days. Place these totals in block number 5).

5. Total Piedmont Medicaid Occupied Bed Days, Current Month Ended Total: Enter the number of ICF-MR occupied bed days payable by Medicaid through the ICF-MR reimbursement program for the current month based on dates of service for clients with a county of residents in the 5 Piedmont Area Counties.

6. Total Private Occupied Bed Days, Current Month Ended Total: Enter the number of any ICF-MR occupied bed days not paid or payable by Medicaid as an ICF-MR day for the current month based on date of service.

7. Total Occupied Bed Days, Current Month Ended Total: Add items 4, 5, 6, then enter the result here.

8. Total Medicaid Occupied Bed Days, Documented Prior Period Adjustments: Enter the net number of previously unreported Medicaid patient day adjustments from prior periods. These adjustments would include patient days classified as Medicaid days that have been reclassified to non-Medicaid days as well as days that were previously classified as non-Medicaid days that were reclassified to Medicaid days. This should not include any Piedmont Medicaid days.

9. Total Piedmont Medicaid Occupied Bed Days, Documented Prior Period Adjustments: Enter the net number of previously unreported Medicaid Occupied Bed day's adjustments from prior periods for clients with a county of residence in the 5 Piedmont Area Counties.

Example A:

Patient I was originally classified as Medicaid for 10 days in the previous month. A determination has been made that Patient I was actually a private pay. These 10 days should be reclassified from Medicaid to Private days. The Medicaid day's impact for this would be decease on 10 days (-10).

Patient II was originally classified as Piedmont Area Counties of resident for 2 days in the previous month. A determination has been made that those days should have been covered by non Piedmont Medicaid days. These 2 days should be reclassified from

Piedmont Area Counties of resident Medicaid days to Non Piedmont Medicaid days. The Medicaid day's impact for this would be an increase of 2 days (+2).

The net number of previously unreported Medicaid patient day adjustments from prior periods would be -8 (-10 plus +2).

A sample worksheet showing this example is attached. This worksheet is not required, but is merely a sample that you may use if you desire. All prior period adjustments must be supported with documentation. The attached sample worksheet is not considered supporting documentation. Supporting documentation may include a FL-2 Medicaid Remittance Advice, or other official documentation.

10. Total Private Occupied Bed Days, Documented Prior Period Adjustments: Enter the number of previously reported Private patient day adjustments for prior periods. These adjustments would include patient days classified as Private days that have be reclassified to Medicaid as well as days that were previously classified as Medicaid days that need to be reclassified to Private days.

Example B:

Patient I was originally classified as Medicaid for 10 days in the previous month. A determination has been made that Patient I was actually a private pay. These 10 days should be reclassified from Medicaid to Private days. The Medicaid day's impact for this would be increase on 10 days (+10).

Patient III was originally classified as Private Pay for 4 days in the previous month. A determination has been made that those days should have been covered by Medicaid. These 4 days should be reclassified from Private Pay to Medicaid. The Medicaid day's impact for this would be a decrease of 4days (-4).

The net number of previously unreported Medicaid patient day adjustments from prior periods would be +6 (+10 plus 4).

A sample worksheet showing this example is attached. This worksheet is not required, but is merely a sample that you may use if you desire. All prior period adjustments must be supported with documentation. The attached sample worksheet is not considered supporting documentation. Supporting documentation may include a FL-2 Medicaid Remittance Advice, or other official documentation.

11. Total Occupied Bed Days, Documented Prior Period Adjustments: Add items 8, 9, and 10 and enter the result here.

Example C:

Patient II was originally classified as Medicaid for 2 days in the previous month. A determination has been made that Patient II was actually a private pay. These 2 days should be reclassified from Medicaid to Private days. The Medicaid day's impact for this would be decease on 2 days (-2).

Patient III was originally classified as Private Pay for 4 days in the previous month. A determination has been made that those days should have been covered by Medicaid. These 2 days should be reclassified from Private Pay to Medicaid. The Medicaid day's impact for this would be an increase of 4 days (+4).

The net number of previously unreported Medicaid patient day adjustments from prior periods would be +2 (-2 plus +4).

A sample worksheet showing this example is attached. This worksheet is not required, but is merely a sample that you may use if you desire. All prior period adjustments must be supported with documentation. The attached sample worksheet is not considered supporting documentation. Supporting documentation may include a FL-2 Medicaid Remittance Advice, or other official documentation.

12. Total Medicaid Days, Adjusted Monthly Total: Add items 4 and 8 then enter the result here.

13. Total Piedmont Medicaid Occupied Bed Days, adjusted Monthly total: Add items 5 and 9 and enter the result here.

14. Total Private Occupied Bed Days, adjusted Monthly total: Add items 6 and 10 and enter the result here.

15. Total Occupied Bed Days, adjusted Monthly Total: Add items 12, 13, and 14, and then enter the result here.

16. Provider Assessment Daily Rate: This is the fixed $9.33 provider tax assessment as indicated on the cover letter that accompanied the reporting packet.

17. Monthly Provider Fee Due: Multiply item15 by item16 and enter the result here. This is the amount of assessment due on or before the 15th of the month following the reporting period. Failure to submit the completed provider fee report and full payment by the due date shall result in penalties and interest as stated in the North Carolina Provider Agreement and Controller Cash Management Plan.

18. Total Medicaid Occupied Bed Days, Year to date Cumulative: Add item 12 from the current period report to item 18 from the previous period report and enter the result here.

19. Total Piedmont Medicaid Occupied Bed Days, Year to date cumulative: Add item 13 from the current period report to item 19 from the previous period report and enter the result here.

20. Total Private Occupied Bed Days, Year to date cumulative: Add item 14 from the current period report to item 20 from the previous period report and enter the result here.

21. Total Occupied Bed Days, Year to Date cumulative: Add items 18, 19, and 21 and enter the result here.

22. Signed by: Upon completion, this form must be signed by an Owner, Partner, Officer or Administrator of the reporting facility. If not signed, the form will be considered incomplete.

23. Date: Date of completion of statement

24. Print Name: Legibly print the name of the individual who signed the form.

25. Title: Title of the individual who signed the form.

26. Telephone: Enter the Telephone number of the individual who signed the form.

27. E-mail: Enter the e-mail address of the individual who signed the form.